Part II

U.S. Embassy_____

Commercial Driver Fitness Determination

Medical Examination Report

Name:	Date of Birth:

Health History:

Driver completes this section, but medical examiner is encouraged to discuss with driver.

Yes NO

☐ ☐ **Any surgery or hospitalization in last 5 years?**

☐ ☐ **Any serious illness in last 5 years requiring medical attention?**

☐ ☐ **Head/Brain Injuries, disorders or illnesses?**

☐ ☐ **Seizures, epilepsy?**

☐ **Medication for seizures:_____**

☐ ☐ **Eye disorders or impaired vision (except corrective lenses)?**

☐ ☐ **Ear disorders, loss of hearing or balance?**

☐ ☐ **Heart disease or attack; other cardiovascular condition?**
☐ **Medication for heart:_____**

☐ ☐ **Heart surgery (valve replacement, bypass, angioplasty, pacemaker)?**

☐ ☐ **High blood pressure?**
☐ **Medication:_____**

☐ ☐ **Muscular disease?**

☐ ☐ **Shortness of breath?**

☐ ☐ **Lung disease, emphysema, asthma, chronic bronchitis, pleurisy?**

Yes No

- ☐ ☐ **Kidney disease, dialysis?**

- ☐ ☐ **Liver disease?**
- ☐ ☐ **Digestive problems?**

- ☐ ☐ **Diabetes or elevated blood sugar controlled by:**
- ☐ **Diet**
- ☐ **Medication:_____**
- ☐ **Insulin**

- ☐ ☐ **Nervous or psychiatric disorders, e.g., severe depression?**

- ☐ ☐ **Loss of or altered consciousness?**

- ☐ ☐ **Fainting, dizziness?**

- ☐ ☐ **Sleep disorders, daytime sleepiness, severe snoring?**

- ☐ ☐ **Stroke or paralysis?**

- ☐ ☐ **Missing or impaired hand, arm, foot, leg,finger, toe?**

- ☐ ☐ **Spinal injury or disease?**

- ☐ ☐ **Chronic, severe low back pain?**

- ☐ ☐ **Regular, frequent alcohol use?**

- ☐ ☐ **Narcotic or habit forming drug use?**

For any YES answer, indicate onset date, diagnosis, medication, treating physician's name and address, and any current limitation.

List any other medications, not already given above, used regularly or recently.

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and the Medical Officer's Driving Certification.

_____ _____

Driver's signature Date

I have verified the identification of the examinee, and have reviewed the history with the examinee.

_____ _____

Medical Reviewer (Examiner) Date

Reviewed and Certified/Rejected by:

_____ _____

Foreign Service Medical Provider (RMO, FSHP) Date